MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Wol + Med, R. West ORT, L. Miner, DC 2436 IH-35 East South, Ste. 336 Denton TX 75205	MDR Tracking No.: M4-03-7195-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 5 Travelers Indemnity Co of Conn 1501 S. MoPac A320 Austin TX 78746	Date of Injury: Employer's Name: Hastings Entertainment, Inc. Insurance Carrier's No.: 039CBBXP1734

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
7/2/02	**9/6/02**	**97799-CP**	**$8,512.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

6/18/03: "Our Position: The carrier denied our services for Chronic Pain Management with the payment exception code "F-fee guideline MAR reduction". There is not MAR for the code 97799-CP. The carrier has failed to comply with Rule 133.304 (c)…Rule 133.304 (l)…"

PART IV: RESPONDENT'S POSITION SUMMARY

6/23/03: Respondent did not submit a position statement.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97799-CP, for DOS 7/21/03 through 9/6/02 were denied "F – The procedure code is reimbursed based on the Medical Fee schedule."
- The denial for CPT code 97799-CP was incorrectly denied by the respondent per Rule 133.304 (c), as the MFG descriptor for the code is reimbursable by DOP, there is not a MAR.
- The requestor submitted convincing evidence that they requested reconsideration on 1/15/03 after receipt of the first set of EOB's according to Rule 133.304 (l). The respondent did not respond with additional EOB's in their response to MDR
- The requestor submitted SOAP/documentation that supports services were rendered, but according to 133.307(g)(3)(D), the requestor did not establish their usual and customary rates. Therefore, additional reimbursement can not be recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

Authorized Signature	Name	Date of Order
		4/13/05

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____